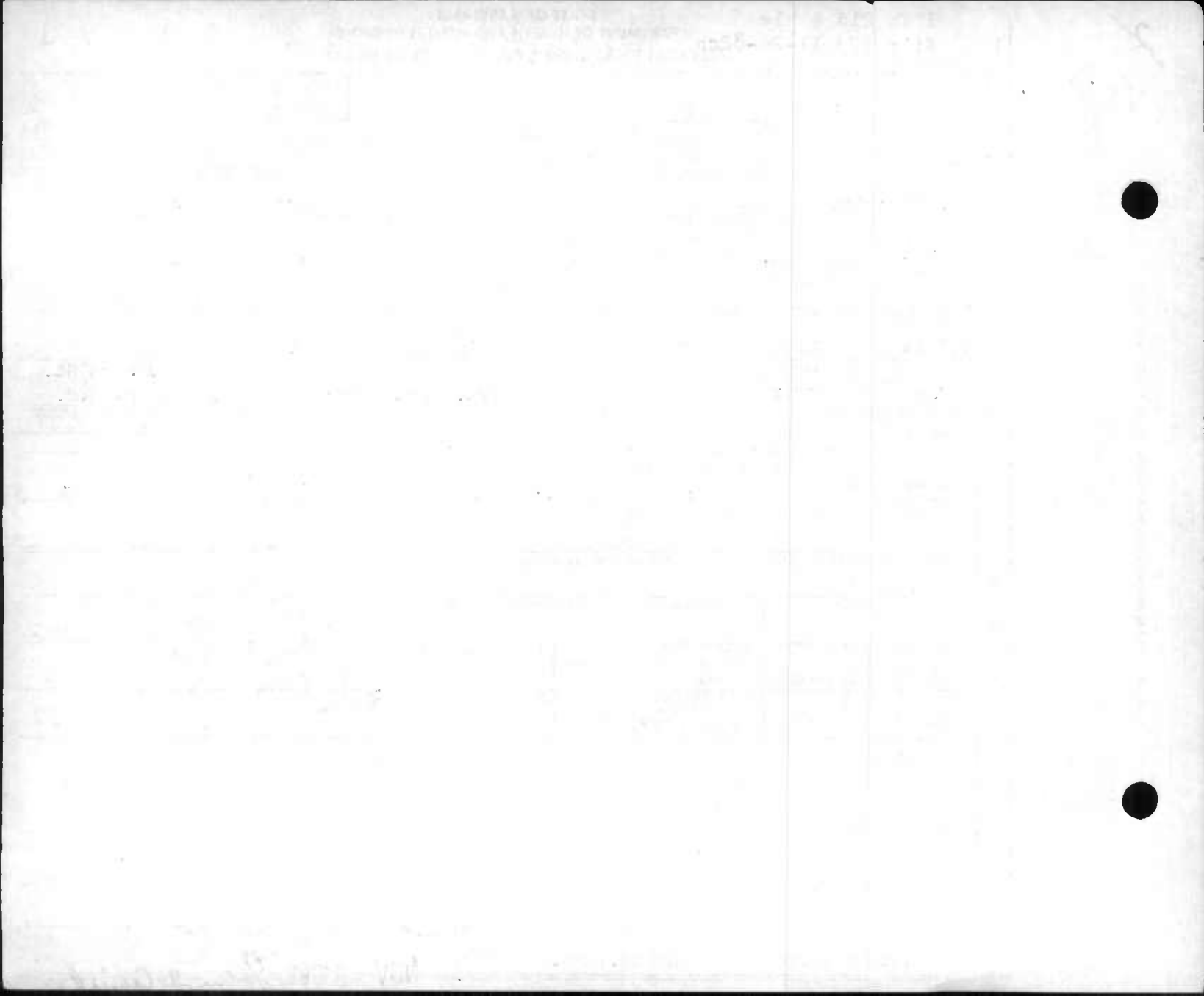


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
ITEM 21d & 21e 1. FOR REGISTRAR Film 573 11-26-82										2 29498	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>James Baker</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 1 19 82</b>		2b. HOUR <b>9<sup>00</sup> PM</b>		
3. SEX <b>male</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 20</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>62 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 1 19 82</b>		7d. HOUR <b>9<sup>00</sup> PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Jessup</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8251 Washington Blvd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeffie Lee Baker</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nina Rebecca Lamn</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>1003 Coburn St.</b> <b>Mrs. Ruth Barrow Roanoke Rapids, N.C.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overwhelming PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>SEVERE hypothermia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Exposure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>ALCOHOL ABUSE</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>PATIENT'S CAR</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>William Polito, MD</b>					TITLE (SPECIFY)			DATE SIGNED <b>1/14/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>William Polito, MD</b>					ADDRESS <b>9226 Bellbeck Rd, Balt. MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>11/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Cawthon</b>				

BP 323



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 4 9 9	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE DORSEY BENSER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 15 82</b>		2b. HOUR <b>10<sup>20</sup> PM</b>			
3. SEX <b>Male</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 10 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD Co., MD.</b>					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Linotype Opr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>HAMPSTEAD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1304 Summit STREET</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wharton Benser</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Melissa Dorsey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Mrs. Eleanor B. Benser</b>		ADDRESS <b>Hampstead, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4274 IMMEDIATE CAUSE (a) Ventricular Fibrillation followed by asystole</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Probable chronic obstructive lung disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15, 19 82</b> to <b>11/15, 19 82</b> , that (I) (we) last saw the deceased alive on <b>11/15, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stephen Zemel MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/15/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen Zemel</b>				22e. ADDRESS <b>Howard County General Hospital ER</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/18/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-1111.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 2 2 9 5 0 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Conway L Blakley</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>23</b> YEAR <b>82</b>		2b. HOUR <b>0416P</b>
3. SEX <b>male</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>10</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>laborer</b>
13a. STATE <b>md</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Tessup</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>#8 7734 Washington Blvd</b>	
14. FATHER'S NAME FIRST <b>Robert Blakley</b> MIDDLE <b>Robert</b> LAST <b>Blakley</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Doris M.</b> MIDDLE <b>Blakley</b> LAST <b>Blakley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>227144611</b>		17. INFORMANT <b>wife</b> ADDRESS <b>Doris M. Blakley 7734 Wash. Blvd #8</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis M.I.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23/82</b> 19 <b>82</b> to <b>11/23</b> 19 <b>82</b> , that (I) (we) lost <b>saw the deceased alive on 11/23</b> 19 <b>82</b> , and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mark Dan</b>		DEGREE		22c. DATE SIGNED <b>11/23/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Dan</b>		22e. ADDRESS <b>9051 Balt Nat Pike E C md 21043</b>		22f. DATE REC'D. BY REGISTRAR <b>NOV 24 1982</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>11/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Dorsey</b>		COUNTY <b>Howard</b>		STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b>		ADDRESS <b>1328 Sulphur Spring Rd.</b>		25a. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

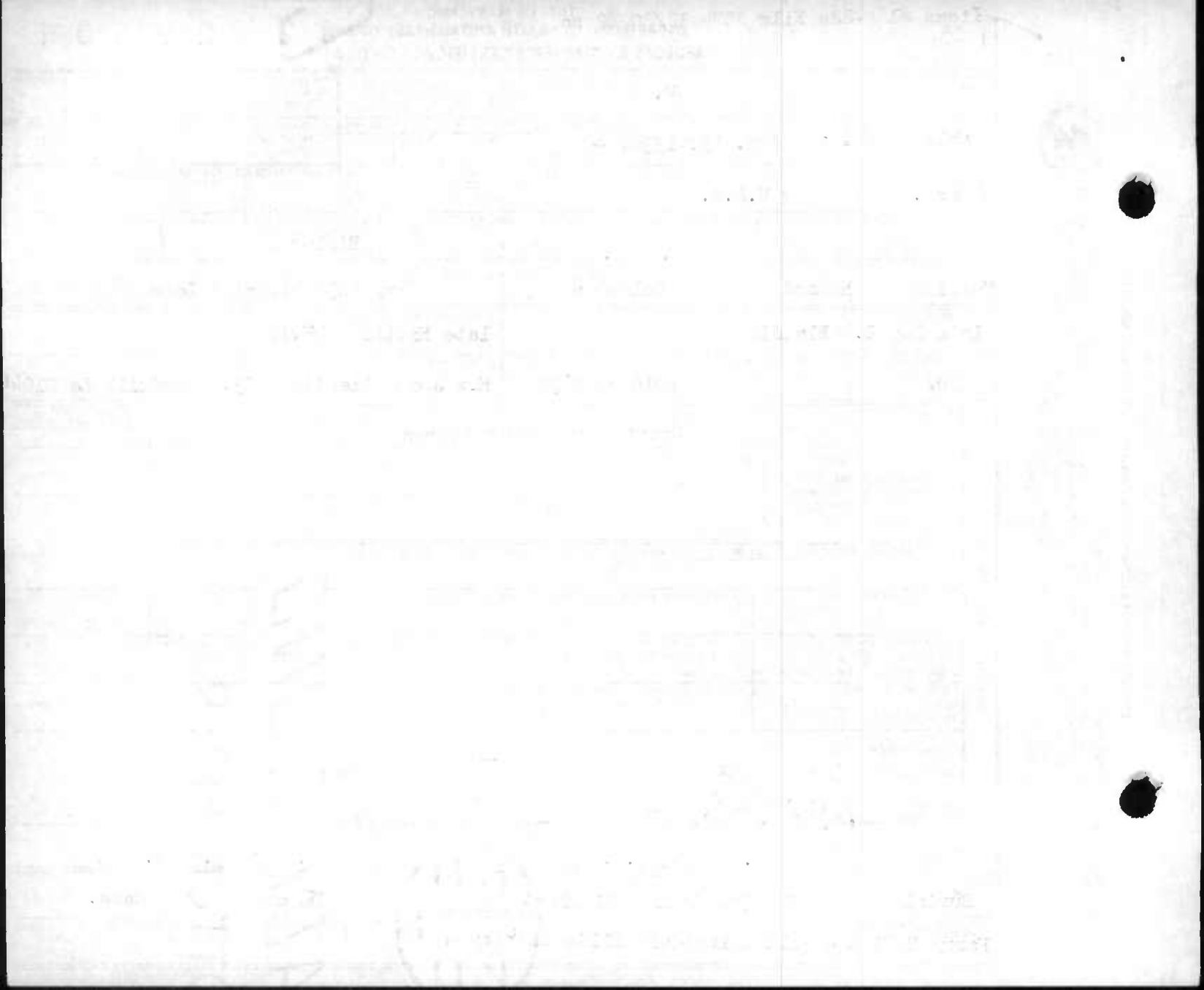
BP

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										2 2 9 5 0 1			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>WARREN W. BLANDIN</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 26 19 82</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 13, 1936</b>		6. AGE (IN YEARS) <b>46</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>11 26 19 82</b>		2d. HOUR <b>2:56</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Biologist</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5234 Windmill Lane</b>			
14. FATHER'S NAME <b>late Roy D. Blandin</b>						15. MOTHER'S MAIDEN NAME <b>late Hattie Davis</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>016 28 0830</b>		17. INFORMANT <b>Mrs Joan Blandin</b>				ADDRESS <b>5234 Windmill La 21041</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Spontaneous pneumothorax</b> <b>5/20</b> IMMEDIATE CAUSE (a) <b>Spontaneous pneumothorax</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Spontaneous pneumothorax</b> (c) <b>Spontaneous pneumothorax</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Ann M. Dixon</b>				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>11-26-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov 30, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dover, Mass.</b>			
24. FUNERAL DIRECTOR <b>Harry H Witzke</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 29 1982</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>					

BP 7/17





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 0 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLEN Jane CAMPBELL</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>19</b> YEAR <b>82</b>			2b. HOUR <b>115P</b> M	
3. SEX <b>Female</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>21</b> YEAR <b>45</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36.</b> YRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD.	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10569 JASON LANE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Jonathan</b> MIDDLE <b>Bland</b> LAST <b>Bland</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>O'Connor</b> LAST <b>O'Connor</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>214-48-1539</b>		17. INFORMANT <b>Jonathan Bland- 10799 Hickory Ridge Place Columbia, Maryland 21044</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BREAST CARCINOMA</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24RS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital attended the deceased from <b>9.10.79</b> 19_____, to <b>11.19.82</b> 19_____, that (I) <del>was</del> last saw the deceased alive on <b>11.15.82</b> 19_____, and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (If not, state I did not view the body after death.)							
22b. DATE SIGNED <b>11.19.82</b>				22c. DATE SIGNED <b>11.19.82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ITA DADISMAN</b>				22e. ADDRESS <b>5977 HARPER'S FARM RD COLUMBIA MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov.22,1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey HO. MD.</b>	
24. FUNERAL DIRECTOR Name <b>H. &amp; Russell C. Witzke</b> Address <b>Funeral Homes P. 5555 Twin Knolls Rd. Columbia, MD. 21045</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the funeral director, pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



11 11 22 1929

ELLEN B. CHURCHILL

CHURCHILL 12 21 45

WILLIAM D.

COLUMBIA WEST VIRGINIA

10 25 1929

TO THE EDITOR OF THE COLUMBIA

WEST VIRGINIA

2125

X

2125

2125

2125

2125

2125

2125

2125

2125

2125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 5 0 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Clara R. Dawson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/12/82</b>		2b. HOUR <b>12<sup>35</sup> P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 24, 1917</b> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Miles Reynolds</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Polly Justice</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>407 18 8314</b>	
17. INFORMANT ADDRESS <b>Robert Lee Dawson 5118 Avoca Ave., 21043</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL Lower LOBE PNEUMONIA</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC BREAST CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>(2) BREAST CANCER</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>UPPER GI Hemorrhage AND GASTRIC OUTLET OBSTRUCTION</b>							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>			
22a. I certify that (I) (this hospital) attended the decedent from <b>July 1, 1980</b> to <b>Nov 12, 1982</b> , that (I) (we) lost the decedent alive on <b>Nov 12, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)							
22b. SIGNATURE <b>Randy L. Reese, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Randy L. Reese</b>		22e. ADDRESS <b>3459 St Johns LA Ellicott City, MD</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 15, 1982</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City Howard Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry HWitzkr 4112 Columbia Rd Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>							

BP

UNITED STATES

DEPARTMENT OF

THE ARMY

WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL

ADJUTANT GENERAL'S OFFICE

WASHINGTON, D. C.

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 0 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (LAST OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
RITA			ANN			DEMPSEY						11-3-82			4:19 PM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 05 31 42			6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.								
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GEN. HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY ---								
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN ELICOTT CITY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 9886 POSTWICK ROAD, 21043					
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS P. CHECKES SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY CHRISTINA GRIERSON			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-40-2516			17. INFORMANT RONALD DEMPSEY			ADDRESS 9886 POSTWICK ROAD 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>5192</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fibrosing mediastinitis 2nd Histoplasmosis 4 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>OBSTRUCTIVE AIRWAYS DISEASE;</u>																	
19a. DATE OF OPERATION <u>N/A</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>11/3/1982</u> to <u>11/3/1982</u> , that (I) (we) last saw the deceased alive on <u>11/3/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>B. J. Farrell M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/3/82</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD P. FARRELL MD			22e. ADDRESS 581 RICHARD WAY, SEVERNA PK MD 21146														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT			23b. DATE 11-06-82			23c. NAME OF CEMETERY OR CREMATORY CREST LAWN MEM. GAR.			23d. LOCATION CITY OR TOWN COUNTY STATE MARRIOTTSTVILLE HOWARD MD.								
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR NOV 5 1982			25b. REGISTRAR'S SIGNATURE <u>Jan J. Ganiel</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

REPORT OF THE COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901

THE COMMISSIONER OF PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901

THE COMMISSIONER OF PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901

THE COMMISSIONER OF PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901

THE COMMISSIONER OF PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901

THE COMMISSIONER OF PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

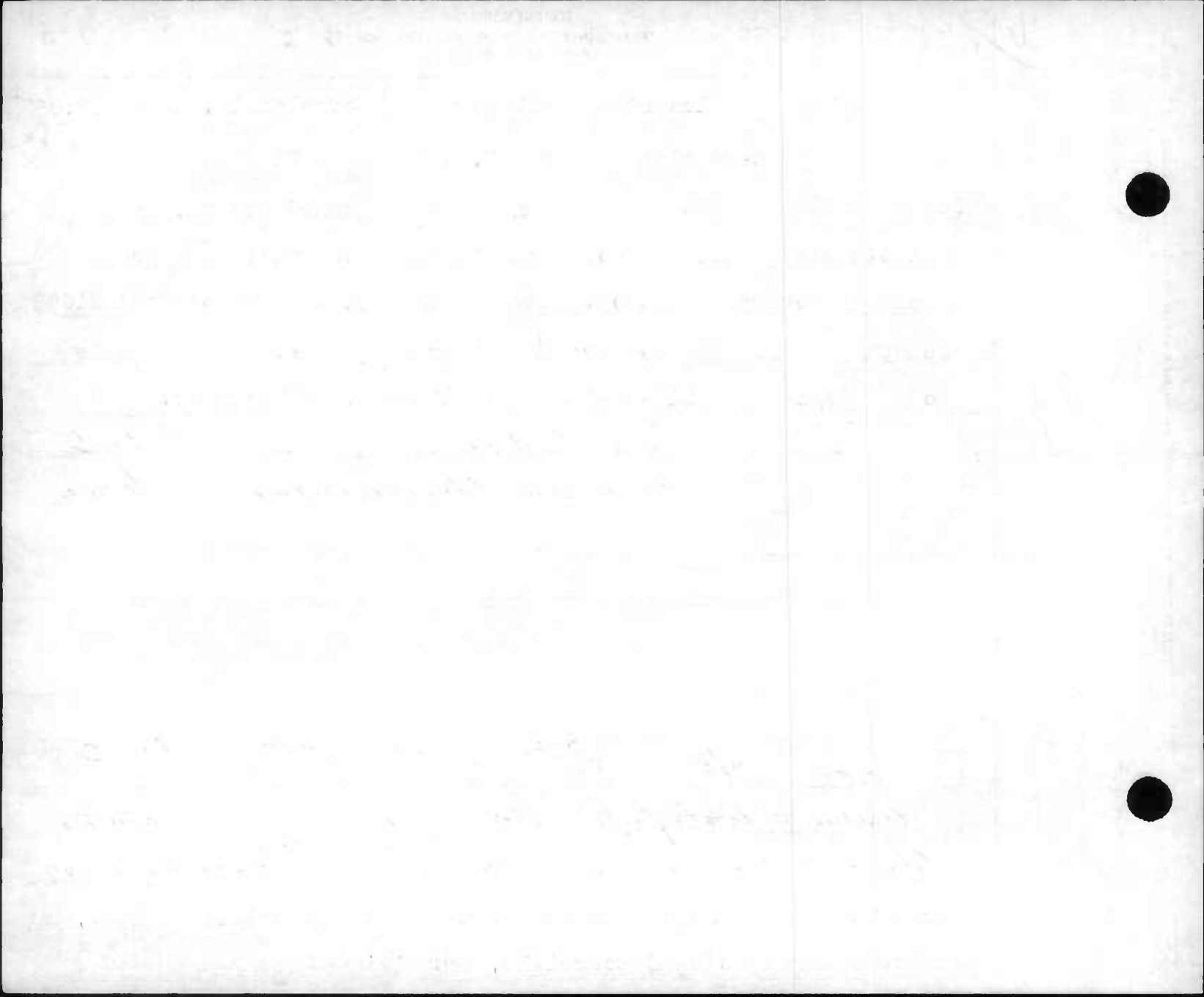
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 5 0 5			
1. DECEASED NAME (TYPE OR PRINT) Helen Elizabeth Gallagher				2a. DATE OF DEATH MONTH DAY YEAR November 11, 1982			
3. SEX Female				2b. HOUR 12:05 PM			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3161 Edgewood Road 21043		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, Maryland MD			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Rodgers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie P. Steele		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Dr. Wilmer K. Gallagher Jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Adenocarcinoma</u> (c) <u>6 mo.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> 19 <u>82</u> to <u>11/11</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>11/5</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <u>William C. Whitefield</u>				22c. DATE SIGNED <u>11/11/82</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William C. Whitefield</u>	
22e. ADDRESS <u>St Agnes Hosp</u> <u>900 Caton Ave Balt Md 21229</u>				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/12/82		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto., MD	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				25a. DATE REC'D. BY REGISTRAR NOV 15 1982			
ADDRESS Catonsville, Md				REGISTRAR'S SIGNATURE <u>John J. Conish</u>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 0 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eileen Gordon</b> <i>EILEEN GORDON</i>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 19, 1982</b>			2b. HOUR <b>7PM</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 28, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS.		6. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9809 Longview Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>9809 Longview Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Francis H Gordon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Mary Daniels</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>087 28 9595</b>		17. INFORMANT ADDRESS <b>Frank Gordon 9809 Longview Dr. 21043</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic failure</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>colon cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>9 mos.</b> <b>9 mos.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>					
22a. I certify that (1) this hospital attended the deceased from <b>March 82</b> to <b>November 19, 1982</b> that (2) (we) last saw the deceased alive on <b>November 3, 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Constance Griffin MD</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>11-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CONSTANCE GRIFFIN MD</b>				22e. ADDRESS <b>JOHNS HOPKINS ONCOLOGY CENTER 600 N. WOLFE ST., BALTIMORE MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard County Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Road Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 0 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Laura More Harbold</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/12/82</b>			2b. HOUR <b>9:00 am</b>	
3. SEX <b>female</b>		4. RACE <b>cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Columbia, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6125 SEBRING DR. (21044)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>COLUMBIA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>6125 SEBRING DRIVE (21044)</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS MERLEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HATTIE WOLF</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>13 7-18-4462</b>		17. INFORMANT <b>6125 SEBRING DR. William F. Harbold Columbia, MD 21044</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MILD CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 WEEK</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSON'S DISEASE.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>82</b> , to <b>11/12</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>11/3</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Evelyn D. Jackson</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Evelyn D. Jackson, M.D.</b>				22e. ADDRESS <b>5540 Ten Oaks Rd, Clarksville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-16-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAWNSIDE CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODSTOWN SALEM, N.J. 1029</b>	
24. FUNERAL DIRECTOR NAME <b>SLACK FUNERAL HOME, ELLICOTT CITY, MD 21045</b>				25. DATE REC'D BY REGISTRAR <b>NOV 16 1982</b>			
				REGISTRAR'S SIGNATURE <b>John J. Calver</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

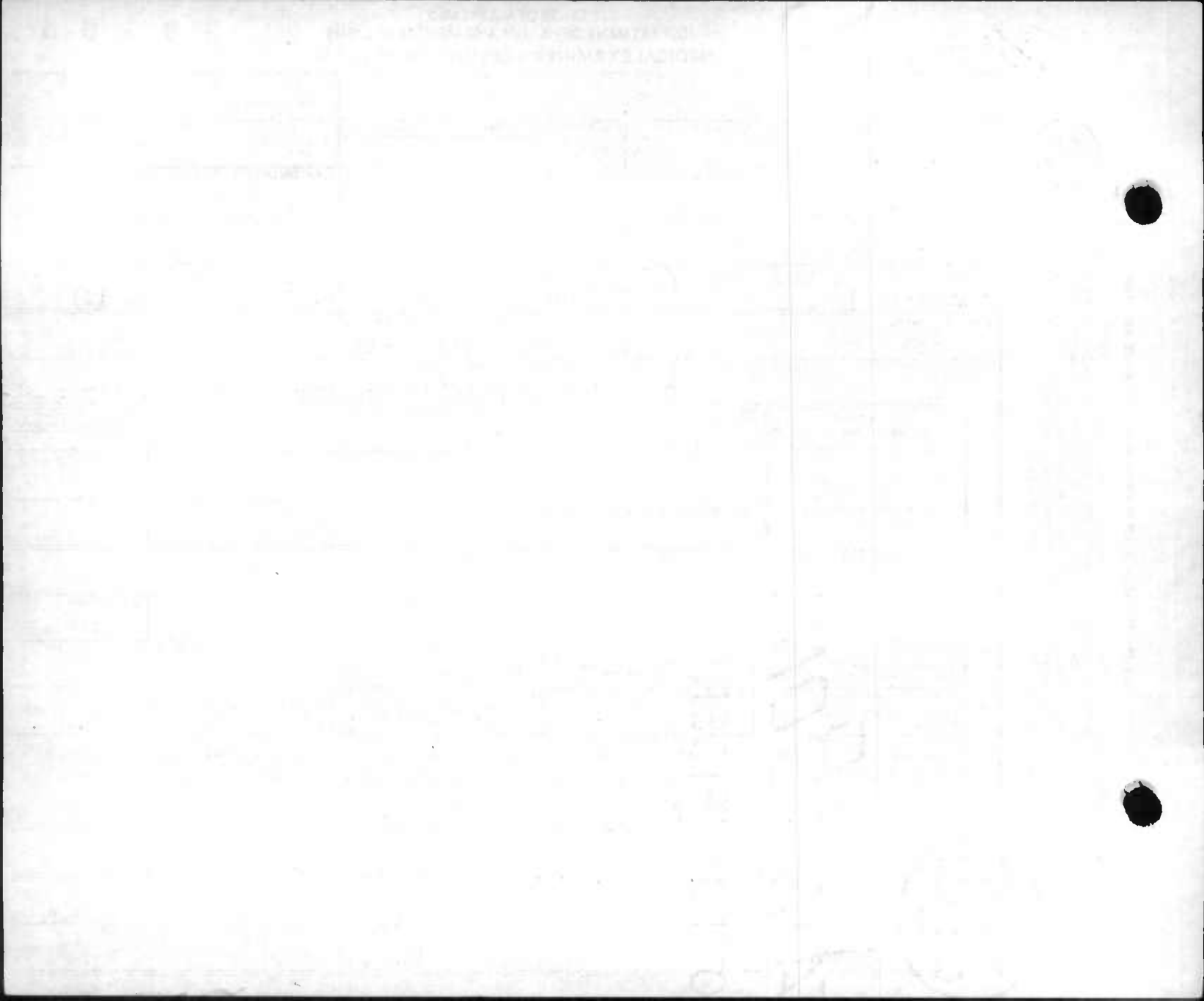


No.	Name of Plant	Family	Genus	Species
1	Cassia	Leguminosae	Cassia	Cassia
2	Cassia	Leguminosae	Cassia	Cassia
3	Cassia	Leguminosae	Cassia	Cassia
4	Cassia	Leguminosae	Cassia	Cassia
5	Cassia	Leguminosae	Cassia	Cassia
6	Cassia	Leguminosae	Cassia	Cassia
7	Cassia	Leguminosae	Cassia	Cassia
8	Cassia	Leguminosae	Cassia	Cassia
9	Cassia	Leguminosae	Cassia	Cassia
10	Cassia	Leguminosae	Cassia	Cassia
11	Cassia	Leguminosae	Cassia	Cassia
12	Cassia	Leguminosae	Cassia	Cassia
13	Cassia	Leguminosae	Cassia	Cassia
14	Cassia	Leguminosae	Cassia	Cassia
15	Cassia	Leguminosae	Cassia	Cassia
16	Cassia	Leguminosae	Cassia	Cassia
17	Cassia	Leguminosae	Cassia	Cassia
18	Cassia	Leguminosae	Cassia	Cassia
19	Cassia	Leguminosae	Cassia	Cassia
20	Cassia	Leguminosae	Cassia	Cassia
21	Cassia	Leguminosae	Cassia	Cassia
22	Cassia	Leguminosae	Cassia	Cassia
23	Cassia	Leguminosae	Cassia	Cassia
24	Cassia	Leguminosae	Cassia	Cassia
25	Cassia	Leguminosae	Cassia	Cassia
26	Cassia	Leguminosae	Cassia	Cassia
27	Cassia	Leguminosae	Cassia	Cassia
28	Cassia	Leguminosae	Cassia	Cassia
29	Cassia	Leguminosae	Cassia	Cassia
30	Cassia	Leguminosae	Cassia	Cassia

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 29508			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD E. HARPER										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 11-8-82 19		2b. HOUR M	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 24 40		6. AGE (IN YEARS) (LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-8-82 19		2d. HOUR 9AM M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Howard County				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN HOSPITAL OR NURSING HOME, GIVE NAME AND ADDRESS) Southbound 1-95, 1/2 mile south of Harbor Tunnel Exit				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2602 E. Oliver St. 21213			
14. FATHER'S NAME FIRST MIDDLE LAST Moses Harper Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Bellamy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 245-56-7552		17. INFORMANT ADDRESS Willie Mae Harper 2602 E. Oliver St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 11-8-82 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) wooded area		21f. LOCATION CITY OR TOWN COUNTY STATE Southbound 1-95, 1/2 mile South of Harbor Tunnel Exit Howard Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margaret A. Koroll, M.D.						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)						DATE SIGNED 11-8-82							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/13/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery Baltimore				23d. LOCATION CITY OR TOWN COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc 1101 E. North Avenue						25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE John J. L... ..					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 333-1300.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Steven</b> MIDDLE <b>E.</b> LAST <b>Jackson</b> <b>Steven E. JACKSON</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>29</b> YEAR <b>82</b> <b>Nov. 29, 1982</b>		2b. HOUR <b>6<sup>57</sup> A</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>15</b> YEAR <b>27</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Columbia</b>			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Chief Pty. Ofc.</b>		12c. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>	
14. FATHER'S NAME FIRST <b>Stephen</b> MIDDLE <b>F.</b> LAST <b>Jackson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Essie</b> MIDDLE <b>Sessions</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2 463-32-9681</b>		17. INFORMANT <b>Mrs. Daisy E. Jackson</b>		
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 Hrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Dis.</b>		<b>8 days yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>February 11-29, 1982</b> , to <b>11/29, 1982</b> , that (1) (we) lost saw the deceased alive on <b>11-29, 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) did not view the body after death.						
22b. SIGNATURE <b>William Parnes</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-29-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM PARNES</b>		22e. ADDRESS <b>11085 Little Patuxent Pkwy Columbia, md. 21044</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/4/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		
23d. LOCATION CITY OR TOWN <b>Dunbar</b>		COUNTY <b>Pennsylvania</b>		STATE		
24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Homes</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 1 - 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>		
25c. ADDRESS <b>5555 Twin Knolls Road, Columbia, Md. 21045</b>						

BP

DEC 1 1930  
J. L. Smith



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 0

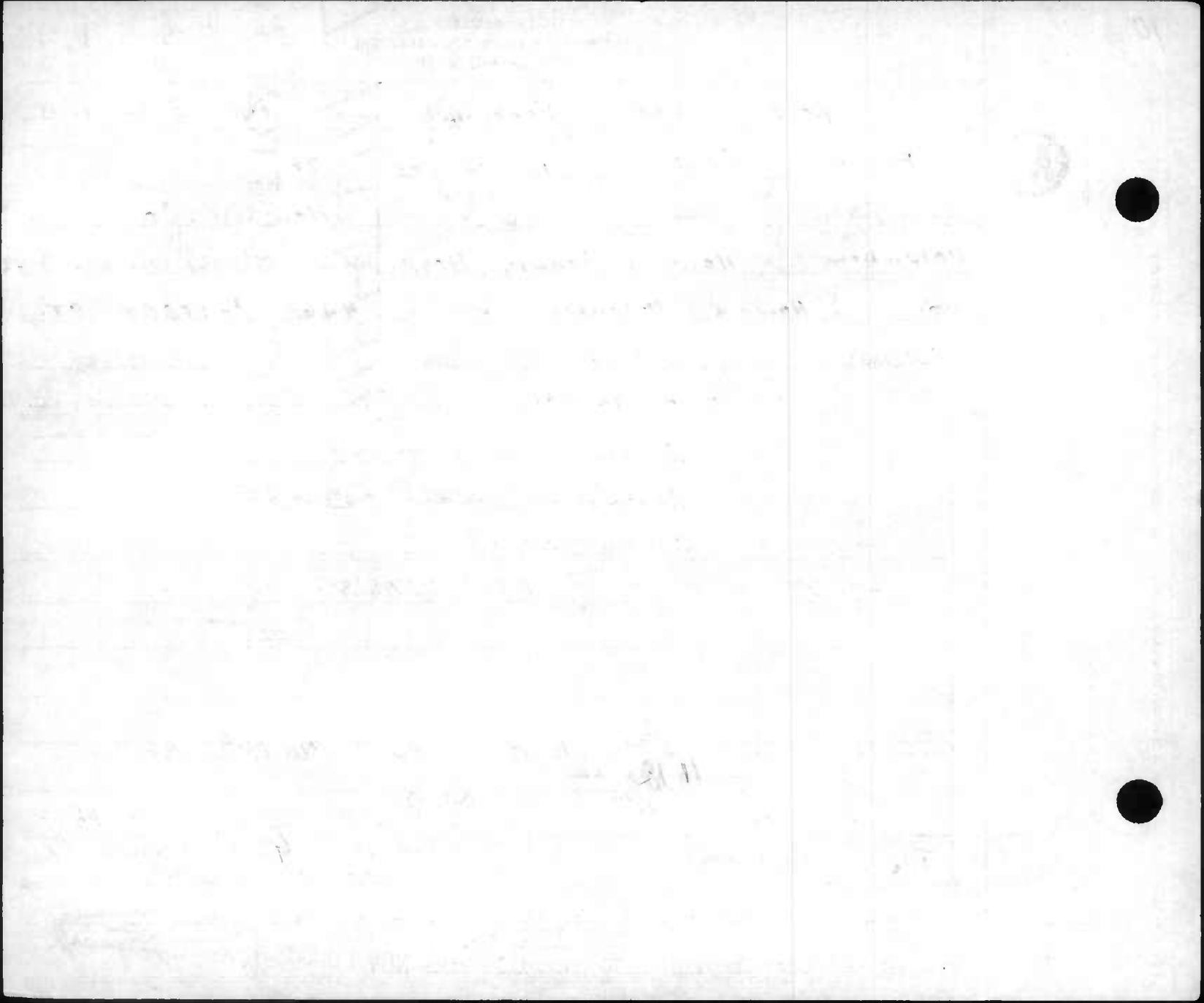
1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rose NMN Kobernick</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 13 82</b>		2b. HOUR <b>10:15<sup>AM</sup></b>						
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 04 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard Co MD</b>					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md. St. Govt</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9465 CATFEET CT.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Markowitz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Kanofsky</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>226424581</b>		17. INFORMANT <b>Zena Klein; 9465 Catfeet Ct., Columbia, Md.</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4254</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOMYOPATHY.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>LYMPHOMA WITH METASTASIS</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10.18.1982</b> to <b>Nov 13<sup>th</sup> 1982</b> , that (I) (we) lost saw the deceased alive on <b>11.13.1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Tariq Mahmood</b>			DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Nov 15 82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TARIQ MAHMOOD</b>			22e. ADDRESS <b>Suite 206 14201 Camel PK Prime Laurel MD 20707</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-14-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden Falls Church, Virginia</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>			ADDRESS <b>Rockville, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PERE (NMN) KONSTANTAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-82</b>		2b. HOUR MIN <b>8:25 A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 8, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>91 0 3</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant-Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md. 21797</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Woodbine</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1438 Hoods Mill Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Konstantas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-07-4973</b>	17. INFORMANT <b>George E. Konstantas, 1438 Hoods Mill Rd. Woodbine, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4360 IMMEDIATE CAUSE (a) Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Acute C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure, Chronic Obstructive Lung Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 P.M. 11 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10802 Hickory Ridge Rd. Columbia Md.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 8, 1982</b> to <b>11/11/82</b> , that (I) (we) last saw the deceased alive on <b>11/11/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. I. Levine</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. I. LEVINE</b>		22e. ADDRESS <b>10802 Hickory Ridge Rd. Columbia Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-15-1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Burrier</b>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ernastine V. Leepa			2a. DATE OF DEATH MONTH DAY YEAR 11 24 82			2b. HOUR 10:20 P.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 15 1890		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Latvia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Fricberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Karlsberg		16. STREET ADDRESS 3518 Belfont Dr. 21043			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 136-26-8776		17. INFORMANT ADDRESS Robert F. Leepa 3518 Belfont Dr. 21043			
18. CAUSE OF DEATH (Enter only one cause per line. If multiple causes, list them in order of importance.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Brain Syndrome, Coma, Seizure Disorder</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>82</u> , to <u>Nov 24</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Nov 24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Laurance Swink</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURANCE SWINK		22e. ADDRESS 3455 ST JOHN'S LA, ELLICOTT CITY					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-27-82		23c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Phillipsburg Warren N.J.	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR NOV 29 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERIKA L. RIISMANDEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-82</b>		2b. HOUR <b>10.05pm</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasion</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Estonia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>md</b>			13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Ellicott City</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Carl August Jurman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Marie Rapp</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 30 6471A</b>		17. INFORMANT ADDRESS <b>Mr. Ants Riisman del 3421 Pierce Drive 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749 IMMEDIATE CAUSE (a)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Breast Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>11g</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <b>James Jurman</b>				22c. DATE SIGNED <b>11-28-82</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Jurman</b>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Dec 2, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Caronsville, Balto, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1982</b>	

MEDICAL CERTIFICATION

BP

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mayme E. Roberts</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 10 82</b>		2b. HOUR <b>6<sup>09</sup> P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 4 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10671 Greenmount Circle</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Everett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Stated</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>Not Stated</b>		17. INFORMANT <b>Herbert O. Roberts Jr., Son,</b>		ADDRESS <b>Washington, D.C., 339 N St., S.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest -</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebrovascular accident</b> (c) <b>Hypertension, essential</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10 24 1982</b> to <b>11 10 1982</b> that (I) (we) lost saw the deceased alive on <b>11 10 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-11-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. HANIF M.D.</b>				22e. ADDRESS <b>6149 Wash. Blvd., Elkridge Md 21227</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>15 Nov 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR NAME <b>W. ERNEST JARVIS CO., INC.,</b>				ADDRESS <b>Washington, D. C.</b>		DATE REC'D. BY REGISTRAR <b>NOV 19 1982</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John Joseph SCHULTZ

2a. DATE KNOWN  
OF DEATH ESTI-  
MATEDMONTH DAY YEAR  
11 26 19 822b. HOUR  
12 20  
M

3. SEX

Male

4. RACE

Cauc

5. DATE OF BIRTH

MONTH DAY YEAR  
12-12-17

6. AGE (IN YEARS)

LAST BIRTHDAY  
64 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

2c. DATE

MONTH DAY YEAR

11-26 1982

2d. HOUR

23 5  
M7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

WASHINGTON, D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Howard County MD.

10. CITY OR TOWN OF DEATH

COLUMBIA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

6503 LACE LIKE ROW

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

C &amp; P TELEPHONE CO.

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

MONTGOMERY

13c. CITY OR TOWN

SILVER SPRING

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

619 RAY DRIVE 20910

14. FATHER'S NAME

FIRST

JOHN

MIDDLE

JOSEPH

LAST

MUIR

15. MOTHER'S MAIDEN NAME

FIRST

MARY

MIDDLE

ELIZABETH

LAST

HUGHES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

578-10-4757

17. INFORMANT

JANE M. SCHULTZ

SAME AS 13

WIFE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

1729

IMMEDIATE CAUSE (a)

Inanition

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Malignant Melanoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

Thomas F. Herbert

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

11-26-82

EXAMINER'S NAME  
(TYPE OR PRINT)

Thomas F. Herbert, MD

ADDRESS

Silver Spring City, Md 21043

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

11/30/82

23c. NAME OF CEMETERY OR CREMATORY

GATE OF HEAVEN

23d. LOCATION  
CITY OR TOWN

SILVER SPRING

COUNTY

MONT

STATE

MD.

24. FUNERAL DIRECTOR  
NAME

FRANCIS J. COLLINS

25a. DATE REC'D. BY REGISTRAR

DEC 3 - 1982

25b. REGISTRAR'S SIGNATURE

John J. Conner

500 UNIV. BLVD., W., SILVER SPRING, MD. 20901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 1 6	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Margaret Dorothy Sossiau					2a. DATE OF DEATH MONTH DAY YEAR 11 16 82				2b. HOUR M 2 00 AM		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 29, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2932 Rogers Ave. (21043)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec.		12b. KIND OF BUSINESS OR INDUSTRY Ho. Co. School			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2932 Rogers Ave. (21043)			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Strehla					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 110 03 2488		17. INFORMANT 2932 Rogers Ave. Murry D. Sossiau Ellicott City, Md. 21043							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>340000</u> <u>years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>82</u> , to <u>Nov</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Nov 8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE <u>Jerry I. Levine</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					27c. DATE SIGNED 11-16-82	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY I. LEVINE, M.D.					27e. ADDRESS 10802 Hickory Ridge Rd Columbia, Md 21044						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremate		23b. DATE 11/17/82		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Maryland					
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043					25. DATE REC'D BY REGISTRAR NOV 16 1982		25. REGISTRAR'S SIGNATURE <u>John J. Conner</u>				

BP



Date	Description	Amount	Total
1912	Jan 1	100.00	100.00
1912	Feb 1	200.00	300.00
1912	Mar 1	300.00	600.00
1912	Apr 1	400.00	1000.00
1912	May 1	500.00	1500.00
1912	Jun 1	600.00	2100.00
1912	Jul 1	700.00	2800.00
1912	Aug 1	800.00	3600.00
1912	Sep 1	900.00	4500.00
1912	Oct 1	1000.00	5500.00
1912	Nov 1	1100.00	6600.00
1912	Dec 1	1200.00	7800.00
1913	Jan 1	1300.00	9100.00
1913	Feb 1	1400.00	10500.00
1913	Mar 1	1500.00	12000.00
1913	Apr 1	1600.00	13600.00
1913	May 1	1700.00	15300.00
1913	Jun 1	1800.00	17100.00

2



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0283531 OR SWINK

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MINNIE J. STEWART</b>			2a. DATE OF DEATH MONTH DAY YEAR <b># 11 11 82</b>		2b. HOUR <b>6<sup>20</sup> P M</b>
3. SEX <b>Female</b>	4. RACE <b>Caus.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 09 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired practical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>nurse</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>9689 Basket Ring RD</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Gillispie</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Matt Stewart 3635 Hilmar Rd Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UPPER GI HEMORRHAGE</b> <b>1560</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC GALLBLADDER ADENOCARCINOMA</b> (c) <b>PEPTIC ULCER DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>METASTASIS TO LIVER AND BONE</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A 1980</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 11 1982</b> to <b>Nov 11 1982</b> , that (I) (we) lost saw the deceased alive on <b>Nov 11 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.					
22b. SIGNATURE <b>Randy L. Reese, M.D.</b>		DEGREE		22c. DATE SIGNED <b>11/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANDY L. REESE</b>		22e. ADDRESS <b>3459 St Johns ELLICOTT CITY, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 14 '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>		ADDRESS <b>4112 Columbia Rd Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>	
		25b. REGISTRAR'S SIGNATURE <b>Randy L. Reese</b>			

55

81

35

130

1

2

9

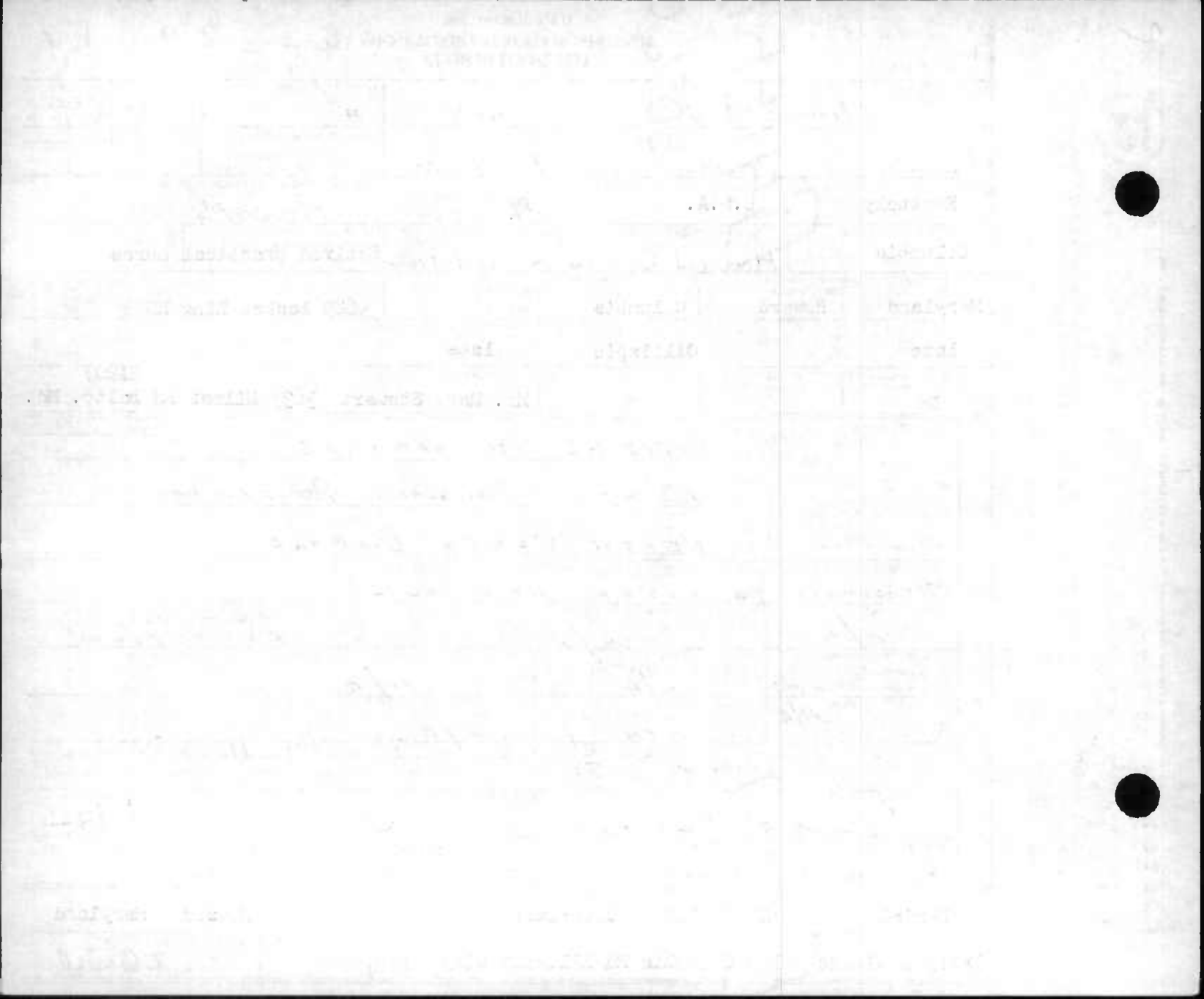
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. No later than 10 days after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 9 5 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY May C. Treulieb Treulieb			2a. DATE OF DEATH MONTH DAY YEAR 11-9-82		2b. HOUR 9:54 AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 5 12 86		
6 AGE (IN YEARS LAST BIRTHDAY) 96		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.		
10 CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Bookkeeper		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME late Peter Treulieb		15. MOTHER'S MAIDEN NAME late Mary				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17 INFORMANT Mrs Gertrude R Torbet		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5314 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastrointestinal hemorrhage (c) Gastric ulcer, suspected		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days Unknown				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 11-7-82 to 11-9-82, that (I) (we) lost saw the deceased alive on 11-9-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
21b. SIGNATURE Charles E Taylor MD		DEGREE MD		22c. DATE SIGNED 11-9-82		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E Taylor MD		22e. ADDRESS 5999 Hopewell Farm Rd. Columbia MD 21044				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov 10'82		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk		
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.		25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE John J. Givier		
24 FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke \$112 Columbia Rd Ellicott City						

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

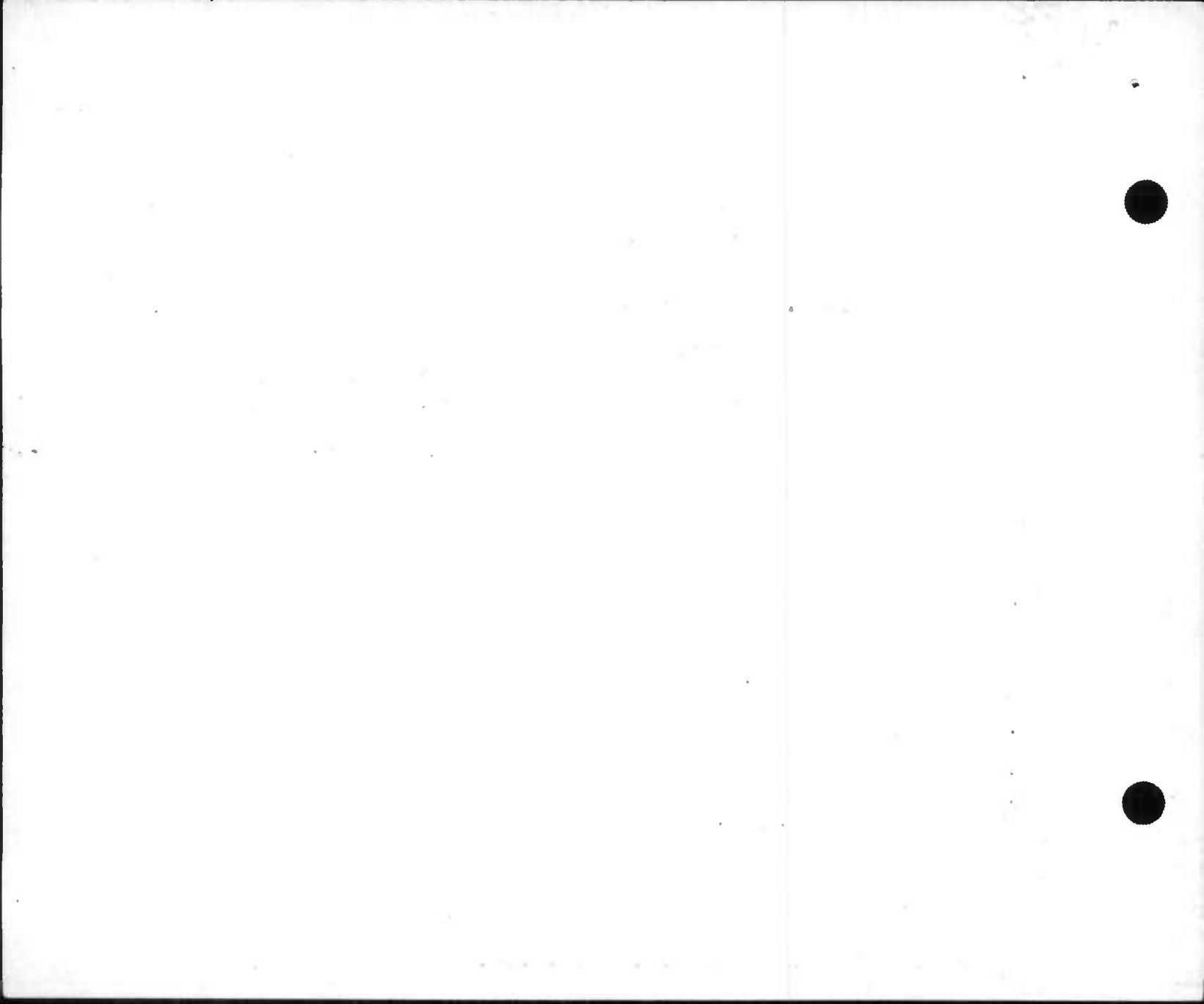
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no autopsy injury, or other traumatic event, the need to examine the body notified by phone.

DHMH-16 20M  
(VRA 15, 4) 7/78

M.E. Dr. Thomas P. Herbert Notified and released to attend. Physician

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 9 5 1 9				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma G. Werner					2a. DATE OF DEATH MONTH DAY YEAR 11 21 82				2b. HOUR 2:38A.M.
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 12 94		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7c. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8119 Thoreau Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Curtis O'Bryan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None					16b. SOCIAL SECURITY NO. 29 3147793		17. INFORMANT Same as above Mary Lou Shuy (Daughter)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 4275 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 10-1-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx @ Hip			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-23 1982 to 11-21 1982, that (I) (we) last saw the deceased alive on 11-21 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE P. Schreiner M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-21-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Schreiner M.D.					22e. ADDRESS Howard County Gen Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/24/82		23c. NAME OF CEMETERY OR CREMATORY Ridgewood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wellston, Ohio			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H. Ave, S.S. Md.					25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE John J. Carver		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 5 2 0		
1 - FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence Therese Williams</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 10, 1982</b>				2b. HOUR <b>2 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 4, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.						
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4012 MacAlpine Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4012 MacAlpine Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Petrick McNulty</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Hanly</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>213-10-26100</b>		17. INFORMANT ADDRESS <b>Ellicott City, Md. 21043</b> <b>Mrs. Dolores E. Kidd, 4012 MacAlpine Court</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic Cardio Vascular 15 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertension</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this physician) attended the deceased from <b>19 60</b> to <b>Nov 10, 19 82</b> that (I) (we) last saw the deceased alive on <b>Nov 8, 19 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.												
22b. SIGNATURE <b>J. Nelson McKay</b> DEGREE <b>M.D.</b>								22c. DATE SIGNED <b>11/10/82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Nelson McKay</b>								22e. ADDRESS <b>11329 Rolling Rd Balto Md. 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedrel Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Witzke Catonsville Funeral Home, P.A.</b>						24b. ADDRESS <b>1630 Edmondson Ave., Catonsville</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Baker</b>		

